TRANSMITTAL SLIP | DATE 6 Nov 1964

TO [redacted]

ROOM [redacted]

REMARKS:

11/9/64

FROM: OC/ISD

ROOM NO.	BUILDING	EXTENSION

FORM NO. 1 FEB 55 241 REPLACES FORM 36-8 WHICH MAY BE USED. ☆ GPO : 1957—O—439445 (47)

STAT

STAT

UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT AND INSURANCE
WASHINGTON 25, D.C.

ADDRESS REPLY TO
"U.S. CIVIL SERVICE COMMISSION"
AND REFER TO
FILE RI:JHF:smr

AND DATE OF THIS LETTER

October 30, 1964

STAT

President
Government Employees Health Association
P. O. Box 463
Washington 4, D. C.

Dear Sir:

Attached are the regulations adopted by the Commission, to become effective November 1, 1964.

You will note that we have not yet arrived at a decision on the advertising regulations. When any further action is taken on the advertising regulations, you will be advised.

Sincerely yours,

Andrew E. Ruddock

Andrew E. Ruddock, Director
Bureau of Retirement and Insurance

Enclosure

ERRATA

The heading "§ 890.306 Effective dates." has been inadvertently omitted. It should be inserted immediately before the second paragraph in the right-hand column of page 14715.

Rules and Regulations

Title 5—ADMINISTRATIVE PERSONNEL

Chapter I—Civil Service Commission

PART 890—FEDERAL EMPLOYEES HEALTH BENEFITS PROGRAM

On June 5, 1964, August 19, 1964, and September 10, 1964, notices of proposed rule making were published in the FEDERAL REGISTER (29 F.R. 7327, 29 F.R. 11844, 29 F.R. 12784), stating that the Civil Service Commission was considering amendment of the regulations governing the Federal Employees Health Benefits Program.

A number of comments were received and given careful consideration. Some of the suggestions for change have been adopted; others, after careful consideration, have not been accepted. In addition, certain clarifying changes have been made and, after careful consideration, it has been decided to extend eligibility for enrollment to employees losing coverage under the Retired Federal Employees Health Benefits Program because of cancellation of the covering enrollment.

There were so many comments, and questions raised, about the proposed advertising rules published as proposed rule making on June 5, 1964 (29 F.R. 7327) that a different rule was drafted and circulated to carriers by letter of October 8, 1964. Comments on this second proposal are still under consideration. Since the regulation changes adopted must become effective by the beginning of the next contract period, November 1, 1964, it is impracticable to delay this revision until a decision can be made on the advertising rules. Consequently, this revision does not alter the present advertising rules except by relocating them in § 890.204. This publication does not terminate the rule-making procedure as to section 890.204 begun by the publication of June 5, 1964 (29 F.R. 7327).

It is ordered, That, effective November 1, 1964, for all sections except § 890.503, and effective on the date of publication for § 890.503, Part 890 of Chapter I of Title 5, Code of Federal Regulations, is amended to read as follows:

Subpart A—Administration and General Provisions

AUTHORITY: The provisions of this Part 890 secs. 890.101 to 890.503 issued under sec. 10, 73 Stat. 715; 5 U.S.C. 3009.

Subpart A—Administration and General Provisions

§ 890.101 Definitions; time computations.

(a) In this part:

(1) Terms defined by section 2 of the Federal Employees Health Benefits Act of 1959 have the meanings there set forth.

(2) "Cancellation" means the act of filing a health benefits registration form terminating enrollment in a health benefits plan and electing not to be enrolled for the future by an enrolled employee or annuitant who is eligible to continue enrollment.

(3) "Change of enrollment" means the registration of an enrolled employee or annuitant to be enrolled for another plan or option, or for a different type of coverage (self alone or self and family), from that for which then enrolled.

(4) "Eligible" means eligible under the law and this part to be enrolled.

(5) "Employing office" means the office of an agency to which jurisdiction and responsibility for health benefits actions for the employee concerned have been delegated. For enrolled annuitants who are not also eligible employees, the office which has authority to approve payment of annuity or workmen's compensation for the annuitant concerned is the employing office.

(6) "Immediate annuity" means an annuity which begins to accrue not later than 1 month after the date enrollment under a health benefits plan would cease for an employee or member of family if he were not entitled to continue enrollment as an annuitant. Notwithstanding the foregoing, an annuity which commences on the birth of the posthumous child of an employee or annuitant is an immediate annuity.

(7) "Option" means a level of benefits. It does not include distinctions as to whether the members of the family are covered.

(8) "Pay period" means the biweekly pay period established pursuant to the Federal Employees Pay Act of 1945, as amended, for the employees to whom that act applies; the regular pay period for employees not covered by that act; and the period for which a single installment of annuity is customarily paid for annuitants.

(9) "Register" means to file with the employing office a properly completed health benefits registration form, either electing to be enrolled in a health benefits plan or electing not to be enrolled. "Register to be enrolled" means to register an election to be enrolled. "Enrolled" means to be enrolled in a health benefits plan approved by the Commission under this part.

(10) "Regular tour of duty" means a work schedule, prescribed in advance to continue indefinitely or for at least 6 months, of a certain number of hours or other time units in a day, week, biweekly pay period, month, or year.

(b) Whenever, in this part, a period of time is stated as a number of days or a number of days from an event, the period is computed in calendar days, excluding the day of the event. Whenever, in this part, a period of time is defined by beginning and ending dates, the period includes the beginning and ending dates.

§ 890.102 Coverage.

(a) Each employee, other than those excluded by paragraph (c) of this section, is eligible to be enrolled in a health benefits plan at the time and under the conditions prescribed in this part.

(b) An employee who serves in cooperation with non-Federal agencies and is paid in whole or in part from non-Federal funds may register to be enrolled within the period prescribed by the Commission for the group of which the employee is a member following approval by the Commission of arrangements providing that (1) the required withholdings and contributions will be made from Federally-controlled funds and timely deposited into the Employees Health Benefits Fund, or (2) the cooperating non-Federal agency will, by written agreement with the Federal agency, make the required withholdings and contributions from non-Federal funds and transmit them for timely deposit into the Employees Health Benefits Fund.

(c) The following employees are not eligible:

(1) An employee serving under an appointment limited to 1 year or less, except an acting postmaster.

(2) An employee whose employment is of uncertain or purely temporary duration, or who is employed for brief periods

at intervals, and an employee who is expected to work less than 6 months in each year, except an employee having a career-conditional or career appointment, or appointed under Schedule B of Part 213 of this chapter, who is employed under a cooperative work-study program of at least 1 year's duration which requires the employee to be in pay status during not less than one-third of the total time required for completion of the program.

(3) An intermittent employee—a non-full-time employee without a prearranged regular tour of duty.

(4) An employee whose salary, pay, or compensation on an annual basis is $350 a year or less.

(5) A beneficiary or patient employee in a Government hospital or home.

(6) An employee paid on a contract or fee basis.

(7) An employee paid on a piecework basis, except one whose work schedule provides for full-time service or part-time service with a regular tour of duty.

(d) The Commission makes the final determination of the applicability of this section to a specific employee or group of employees.

§ 890.103 Employee appeals, corrections, and adjustments.

(a) An employee or annuitant may appeal a refusal of an employing office to permit him to register to enroll, or to change enrollment. The appeal shall be made in writing, within 30 days of the refusal, to the Bureau of Retirement and Insurance, United States Civil Service Commission, Washington, D.C., 20415.

(b) An employee or annuitant may appeal a refusal of the Bureau of Retirement and Insurance to permit him to register to enroll, or to change enrollment. The appeal shall be made in writing, within 90 days of the refusal, to the Board of Appeals and Review, United States Civil Service Commission, Washington, D.C., 20415.

(c) (1) The employing office may make prospective correction of administrative errors as to enrollment at any time.

(2) The Bureau of Retirement and Insurance may order correction of an error, mistake, or omission upon a showing satisfactory to the Bureau that it would be against equity and good conscience not to do so.

(3) The Bureau of Retirement and Insurance may order the termination of an employee's or annuitant's enrollment in a group-practice plan and permit his enrollment in another plan upon a showing satisfactory to the Bureau that the furnishing of adequate medical care is jeopardized by a seriously impaired relationship between a patient and the plan's medical staff.

(d) The Commission does not adjudicate individual claims for payment or service under health benefits plans, nor does it arbitrate or attempt to compromise disputes between an employee or annuitant and his carrier as to claims for payment or service.

§ 890.104 Legal actions.

An action to compel enrollment of an employee or annuitant not excluded by § 890.102(c) should be brought against the employing office. An action to recover on a claim for health benefits should be brought against the carrier of the health benefits plan. An action to review the legality of the Commission's regulations or a decision made by the Commission should be brought against the United States Civil Service Commissioners, Washington, D.C., 20415.

Subpart B—Health Benefits Plans

§ 890.201 Minimum standards for health benefits plans.

(a) To be qualified to be approved by the Commission, a health benefits plan shall:

(1) Comply with the Federal Employees Health Benefits Act of 1959 and this part, as amended from time to time.

(2) Accept the enrollment, in accordance with this part, and without regard to age, race, sex, health status, or hazardous nature of employment, of each eligible employee and annuitant except that a plan which is sponsored or underwritten by an employee organization may not accept the enrollment of a person who is not a member of the organization, but it may not limit membership in the organization on account of these prohibited factors. The carrier may terminate the enrollment of an employee or of an annuitant, other than a survivor annuitant, in a health benefits plan sponsored or underwritten by an employee organization on account of termination of membership in the organization. A comprehensive medical plan need not enroll an employee or annuitant residing outside geographic areas specified by the plan. A carrier who wishes to terminate the enrollment of an employee or annuitant under this subparagraph may do so by notifying the employing office in writing, with a copy of the notice to the employee. The termination is effective at the end of the pay period in which the employing office receives the notice.

(3) Provide health benefits for each enrolled employee and annuitant and covered member of their families wherever they may be.

(4) Provide for conversion to a contract for health benefits regularly offered by the carrier, or an appropriate affiliate, for group conversion purposes, which shall be guaranteed renewable, subject to such amendments as apply to all contracts of this class, except that it may be canceled for fraud, over-insurance, or nonpayment of periodic charges. A carrier shall permit conversion within the time allowed by the temporary extensions of coverage provided under section 890.401 for each employee, annuitant, and member of family entitled to convert. When an employing office gives an employee written notice of his privilege of conversion, the carrier shall permit conversion at any time before (i) 15 days after the date of notice or (ii) 75 days after his enrollment is terminated, whichever is earlier. When the Commission requests an extension of time for conversion because of delayed determination of ineligibility for immediate annuity, the carrier shall permit conversion until the date specified by the Commission in its request for extension. On conversion, the contract becomes effective as of the day following the last day of the temporary extension, and the employee, annuitant, or member of the family, as the case may be, shall pay the entire cost thereof directly to the carrier. The nongroup contract may not deny or delay an obstetrical or other benefit covered by the contract for a person converting from a plan approved under this part, except to the extent that benefits are continued under the health benefits plan from which he converts.

(5) Provide that each employee and annuitant who enrolls in the plan receive an identification card or cards or other evidence of his enrollment.

(6) Provide a standard rate structure which contains, for each option, one standard individual rate, and one standard family rate, without geographical or other variations.

(7) Maintain statistical records regarding the plan, separately from those of any other activities conducted or benefits offered by the carrier sponsoring or underwriting the plan.

(8) Provide for a special reserve for the plan. The carrier shall account for amounts retained by it as reserves for the plan separately from reserves maintained by it for other plans. The carrier shall invest the special reserve and income derived from the investment of the special reserve shall be credited to the special reserve. If the contract is terminated or approval of the plan is withdrawn, the carrier shall return the special reserve to the Employees Health Benefits Fund. However, in the case of a group-practice plan, the carrier, without regard to the foregoing provisions of this subparagraph, shall follow such financial procedures as are mutually agreed on by the carrier and the Commission.

(9) Provide for continued enrollment to the end of the then current pay period of each employee and annuitant enrolled at the effective date of termination of a contract. The carrier is entitled to subscription charges for this continued enrollment.

(b) To be qualified to be approved by the Commission, a health benefits plan shall not:

(1) Deny a covered person a benefit provided by the plan for a service performed on or after the effective date of coverage solely because of a pre-existing physical or mental condition, except that a plan may provide benefits for dentistry or cosmetic surgery, or both, limited to conditions arising after the effective date of coverage; or require a waiting period for any covered person for benefits which it provides, except that a plan, with the approval of the Commission, may limit benefits for services performed for a person, other than a person changing from one plan to another because his health benefits plan is discontinued in whole or part or changing pursuant to an order of the Bureau of Retirement and Insurance, who, on the effective date of enrollment or change of enrollment, is confined in a hospital or other institution, so long as the person is continuously confined therein. In this subparagraph "continuously confined" means one or

more periods of confinement without a break of 31 consecutive days between actual confinements, except that a carrier by agreement with the Commission may provide that a shorter break terminates a continuous confinement.

(2) Have more than two options.

(3) Have an initiation, service, enrollment, or other fee or charge in addition to the rate charged for the plan, except that a comprehensive medical plan may impose an additional charge to be paid directly by the employee or annuitant for certain medical supplies and services, if the supplies and services on which additional charges are imposed are clearly set forth in advance and are applicable to all employees and annuitants. This subparagraph does not apply to charges for membership in employee organizations sponsoring or underwriting plans.

§ 890.202 Minimum standards for health benefits carriers.

The Commission shall approve a health benefits plan only when the carrier of the plan meets the requirements of the Federal Employees Health Benefits Act of 1959, as amended, and the following requirements:

(a) It must be lawfully engaged in the business of supplying health benefits.

(b) It must have, in the judgment of the Commission, the financial resources and experience in the field of health benefits to carry out its obligations under the plan.

(c) It must agree to keep such reasonable financial and statistical records and furnish such reasonable financial and statistical reports with respect to the plan as may be requested by the Commission.

(d) It must agree to permit representatives of the Commission and of the General Accounting Office to audit and examine its records and accounts which pertain, directly or indirectly, to the plan at such reasonable times and places as may be designated by the Commission or the General Accounting Office.

(e) It must agree to accept, subject to adjustment for error or fraud, in payment of its charges for health benefits for all employees and annuitants enrolled in its plan, the enrollment charges received by the Employees Health Benefits Fund less the amounts set aside for the administrative and contingency reserves prescribed in § 890.503. The Commission will pay over the amounts due each carrier at such times as are agreed on by the carrier and the Commission.

(f) A carrier which is an employee organization must agree to continue coverage, without requirement of membership, of any eligible survivor annuitants.

§ 890.203 Application for approval of, and proposal of amendments to, health benefits plans.

(a) Application for approval of comprehensive medical plans may be made by letter to the United States Civil Service Commission, Washington, D.C., 20415. Approval of a plan will become effective on a date to be set by the Commission for the plan. An application received less than 6 months in advance of a contract period will not be approved for that contract period.

(b) Any proposal for change in a health benefits plan shall be in writing, specifically describe the change proposed, and be signed by an authorized official of the carrier. The Commission will review a proposal for change and notify the carrier whether it accepts the change and may make a counterproposal or at any time propose changes on its own motion. The Commission will not consider until after the expiration of the then current contract period any proposal for change which is received less than 6 months before the expiration of the then current contract period, except that changes in subscription charges for the ensuing contract period may be proposed not less than 4 months before the expiration of the then current contract period.

§ 890.204 Advertising and publicity.

A carrier may not advertise a plan approved under the Federal Employees Health Benefits Program, or its participation in the program, to employees, or solicit enrollment of employees in a plan approved under the program, other than in accordance with the instructions of the Commission.

§ 890.205 Withdrawal of approval of health benefits plans.

(a) The Commissioners may withdraw their approval of a health benefits plan.

(b) Before withdrawing approval of a plan, the Commissioners shall cause to be sent, by certified mail, a notice to the carrier stating that they intend to withdraw their approval, and giving the reasons therefor. The carrier is entitled to reply in writing within 15 days of its receipt of the notice, stating the reasons why approval should not be withdrawn.

(c) On receipt of the reply, or in the absence of a timely reply, the Commissioners shall set a time and place for hearing. The Commissioners shall conduct the hearing or designate a representative to do so, unless the carrier waives hearing. The carrier shall be given notice thereof, by certified mail, at least 15 days in advance of the hearing. The carrier is entitled to appear by representative and present oral and written evidence and argument in opposition to the proposed action.

(d) The Commissioners shall make their decision on the record and communicate it to the carrier by certified mail. The Commissioners may set a future effective date for withdrawal of their approval.

(e) The Commissioners, in their discretion, may reinstate approval of a plan on a finding that the reasons for withdrawing approval no longer exist.

Subpart C—Registration and Enrollment

§ 890.301 Opportunities to register to enroll and change enrollment.

(a) *Initial registration.* Except as otherwise provided in this part, each employee who becomes eligible shall register within 31 days after becoming eligible.

(b) *Belated registration.* When an employing office determines that an employee was unable, for cause beyond his control, to register to be enrolled or to change his enrollment within the time limits prescribed by this section, that office shall accept his registration within 31 days after it advises him of that determination.

(c) *Reregistration.* An employee whose enrollment was terminated under § 890.304(a)(4), or because he had a break in service of more than 3 days, or because he was furloughed by reason of reduction in force, shall register within 31 days after his return to pay status.

(d) *Open season.* (1) Not less often than once every 3 years, the Commission by regulation shall provide every employee an opportunity for enrollment and change of enrollment, on such terms and conditions as it may prescribe.

(2) During the period February 1 to February 15, 1965, an employee who is not registered to be enrolled may register to to be enrolled, and any enrolled employee or annuitant may change his enrollment from one plan or option to another, or from self alone to self and family, or both.

(e) *Change in family status.* An enrolled employee or annuitant may register to change his enrollment from self alone to self and family, or from one plan or option to another, or both, and an employee, if registered not to be enrolled, may register to be enrolled, at any time during the period beginning 31 days before a change in marital status and ending 60 days after the change in marital status. An enrolled employee or annuitant may change his enrollment from self alone to self and family within 60 days after any other change in family status.

(f) *Change to self alone.* An employee or annuitant may register at any time to change his enrollment from self and family to self alone. An employee or annuitant who is covered by the enrollment of another under this part may register to be enrolled for self alone within 31 days after a registration to change the covering enrollment has been filed under authority of this paragraph.

(g) *Loss of coverage under Federal programs.* (1) An employee who is not enrolled, but is covered by Chapter 55 of Title 10, United States Code (referred to in this paragraph as Medicare) or by an enrollment under Part 891 of this chapter, may register to be enrolled within 31 days after termination of coverage under Medicare or the enrollment, other than because of death, and within 60 days after termination, because of death, of Medicare or the enrollment.

(2) An employee who is not enrolled, but is covered by the enrollment of another under this part, may register to be enrolled within 31 days after termination of his coverage under the other's enrollment, other than because of death or cancellation, and within 60 days after termination, because of death, of the other's enrollment.

(3) An employee annuitant who was covered by the enrollment of another under this part and had been covered (including enrollment in his own right)

under this part since his first opportunity or for the 5 years immediately preceding his retirement, whichever is shorter, may register to enroll within 31 days after the termination of the covering enrollment, other than by cancellation.

(h) *Move from area served by comprehensive medical plan.* If a comprehensive medical plan limits full service to a geographic area, an employee or annuitant enrolled in that plan who moves outside the full service area or, if already living outside the full service area, moves farther from the full service area, may register, at any time after the move, to be enrolled in another health benefits plan.

(i) *Termination by employee organization plan.* An employee or annuitant who is enrolled in a health benefits plan sponsored or underwritten by an employee organization and whose membership in the employee organization is terminated, may register, if the plan terminates his enrollment, within 31 days after termination of his enrollment in the employee organization plan, to be enrolled in another health benefits plan. However, the employee or annuitant may not change his enrollment from self alone to self and family.

(j) *Transfer to or from overseas post of duty.* An employee who is transferred from a post of duty within the several States or the District of Columbia to a post of duty outside the several States and the District of Columbia, or the reverse, may register to be enrolled or to change his enrollment with respect to whether his family is covered, or the health benefits plan or option in which he is enrolled, or both, within the period beginning 31 days before the date he leaves the old post of duty and ending 31 days after he arrives at the new post of duty. An annuitant who is eligible to continue health benefits may register to change enrollment with respect to whether his family is covered, or the health benefits plan or option in which enrolled, or both, within 60 days after retirement or the death of the employee on whose service title to annuity is based, if the employee is stationed at a post of duty outside the several States and the District of Columbia at the time of his retirement or death, as the case may be.

(k) *Termination of plan in which enrolled.* If a plan is discontinued in whole or part, each employee and annuitant whose enrollment is thereby terminated may enroll in another plan. If the discontinuance is at the end of a contract period which is immediately preceded by an open season, the time for enrollment is the open season. Otherwise the Commission shall establish, by order, a time and effective date for enrollment. Persons who fail to change enrollment within the time set are considered to have cancelled their enrollments, except that if one option of a plan is discontinued, enrolled employees and annuitants who do not change plans will be considered enrolled in the remaining option of the plan.

(l) *On reaching 19.* An employee who is not registered to be enrolled may register to be enrolled within 31 days after he becomes 19 years of age.

(m) *On return from a uniformed service.* An employee who enters on duty in a uniformed service for a period of time not limited to 30 days or less may register to be enrolled or to change his enrollment within 31 days after he is restored to a civilian position pursuant to Part 353 of this chapter or other similar authority; and an annuitant who enters on duty in a uniformed service for a period of time not limited to 30 days or less may register to change his enrollment within 31 days after he is separated from the uniformed service.

(n) *Change in employment status.* If an employee or annuitant is entitled to provide coverage for another by a self-and-family enrollment, but both are enrolled for self alone, he may change his enrollment to self and family within 31 days after the other enrollment is terminated by a change in employment status which results in loss of eligibility.

(o) *Sole survivor.* When an employee or annuitant enrolled for self and family dies, leaving a survivor annuitant who is entitled to continue the enrollment in a health benefits plan, and it is apparent from available records that the survivor annuitant is the sole survivor entitled to continue enrollment in the health benefits plan, the office of the retirement system which is acting as employing office shall change the enrollment from self and family to self alone, effective on the commencing date of annuity for the survivor annuitant. On request of the survivor annuitant made within 31 days after the first installment of annuity is paid, the office of the retirement system which is acting as employing office shall rescind the action retroactive to the effective date of the action, with corresponding adjustment in withholdings and contributions.

(p) *Annuity insufficient to pay withholdings.* If the annuity of an annuitant or of all annuitants in a family is not sufficient to pay the withholdings for the plan in which the annuitants are enrolled, the employing office shall notify the annuitant of the plans available at a cost not in excess of the annuity. The annuitant may register to be enrolled in another plan whose cost is no greater than his annuity.

(q) *Registration by proxy.* In the discretion of the employing office, a representative of the employee or annuitant having a written authorization to do so may register for him.

(r) *Public Law 88-284.* An annuitant who becomes eligible to continue his enrollment by virtue of Public Law 88-284 may register, at any time before December 31, 1964, to be enrolled.

§ 890.302 Coverage of family members.

(a) *Family enrollment.* An employee or annuitant who enrolls for self and family includes in his enrollment all members of his family who are eligible to be covered by his enrollment, but no person may be covered by two enrollments.

(b) *Child incapable of self-support.* When an employee or annuitant enrolls for a family which includes a child incapable of self-support who has become 21 years of age, the employing office shall require the employee or annuitant to submit a certificate of the physician that the child is incapable of self-support because of a physical or mental disability which existed before the child became 21 years of age, and can be expected to continue for more than 1 year. The certificate shall include a statement of the name of the child, the nature of his disability, the period of time it has existed, and its probable future course and duration. The certificate shall be signed by the physician and show his office address. When an employee or annuitant is enrolled for a family which includes a child under 21 years of age who is incapable of self-support because of a physical or mental disability, the employing office shall require the employee or annuitant to submit the certificate on or before the date the child becomes 21 years of age. However, the employing office may accept otherwise satisfactory evidence of incapacity not timely filed.

(c) *Renewal of certificates of incapacity.* The employing office shall require the employee or annuitant who has submitted a certificate of incapacity to renew that certificate on the expiration of the minimum period of disability certified.

(d) *Determination of incapacity.* The employing office shall make determinations of incapacity.

§ 890.303 Continuation of enrollment.

(a) *On transfer.* Except as otherwise provided by this part, the registration of an employee or annuitant eligible to continue enrollment continues without change when he (1) moves from one employing office to another, without a break in service of more than 3 days, whether the personnel action is designated as a transfer or not, or (2) changes from one employing office to another by reason of reemployment, if he is an annuitant, or by reason of retirement under conditions making him eligible to continue enrollment. For the purpose of this part, an employee is considered to have enrolled at his first opportunity if he registered to be enrolled during the first of the periods set forth in section 890.301 in which he was eligible to register or was covered at that time by the enrollment of another employee, or registered to be enrolled effective not later than December 31, 1964.

(b) *Change of enrolled employees to certain excluded positions.* Employees and annuitants enrolled under this part who move, without a break in service or after a separation of 3 days or less, to an employment in which they are excluded by § 890.102(c), continue to be enrolled so long as they are employed full-time, or part-time with a regular tour of duty, unless excluded by subparagraphs (3), (4), (5), (6), or (7) of § 890.102(c).

(c) *On death.* The enrollment of a deceased employee or annuitant who is enrolled for self and family is transferred automatically to his eligible survivor annuitants. The enrollment is considered to be that of the survivor annuitant from whose annuity all or the greatest por-

tion of the withholding for health benefits is made. It covers members of the family of the deceased employee or annuitant. A remarried spouse is not a member of the family of the deceased employee or annuitant.

(d) *Survivor annuitants.* If an employee who is entitled to health benefits coverage as a survivor annuitant elects to enroll or to continue to be enrolled under his eligibility as an employee, and is thereafter separated without entitlement to continued enrollment based on his own service, he is entitled to reinstatement of his employee-acquired enrollment on application to his retirement office. Reinstatement is effective immediately after termination of his employee-acquired enrollment if the application is received by the retirement office within 60 days of separation; otherwise reinstatement is effective on the first day of the first pay period after receipt of the application. The retirement office shall withhold from the annuity that the former employee receives as a survivor annuitant, the amounts necessary to pay his share of the cost of the enrollment.

(e) *In nonpay status.* The enrollment of an employee continues without cost to the employee while he is in nonpay status for up to 365 days. The 365 days' nonpay status may be continued or broken by periods of less than 4 consecutive months in pay status. If an employee has at least 4 consecutive months in pay status after a period of nonpay status he is entitled to begin the 365 days' continuation of enrollment anew. For the purposes of this paragraph, 4 consecutive months in pay status means any four-month period during which the employee is in pay status for at least part of each pay period.

§ 890.304 Termination of enrollment.

(a) *Employees.* An employee's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the earliest of the following dates:

(1) The last day of the pay period in which he is (i) furloughed by reason of reduction in force, or (ii) separated from the service other than by retirement under conditions entitling him to continue his enrollment.

(2) The last day of the pay period in which his employment status changes so that he is excluded from enrollment.

(3) The last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant.

(4) The day on which the continuation of enrollment under § 890.303(e) expires, or, if he is not entitled to any further continuation because he has not had 4 consecutive months of pay status since exhausting his 365 days' continuation of coverage in nonpay status, the last day of his last pay period in pay status.

(5) The day he is separated, furloughed, or placed on leave of absence in accordance with the provisions of Part 353 of this chapter or other similar authority for the purpose of performing duty not limited to 30 days or less in a uniformed service.

(b) *Annuitants.* (1) If the annuity of an annuitant or of all survivor annuitants in a family is not sufficient to pay the withholdings for the plan in which the annuitants are enrolled, and the annuitant does not, or cannot, elect a plan under § 890.301(p) at a cost to him not in excess of the annuity, the employing office shall terminate the annuitant's enrollment effective as of the end of the last period for which withholding was made. Each annuitant whose enrollment is so terminated is entitled to a 31-day extension of coverage for conversion.

(2) An annuitant's enrollment terminates, subject to the temporary extension of coverage for conversion, at midnight of the last day of the pay period in which he dies, unless he leaves a member of the family entitled to continue enrollment as a survivor annuitant, or, if his enrollment is not terminated by death, at midnight of the earliest of the following dates:

(i) The last day of the last pay period for which he is entitled to annuity, unless he is eligible for continued enrollment as an employee in which case his enrollment continues without change.

(ii) The last day of the pay period in which his title to compensation under the Federal Employees' Compensation Act, as amended, terminates, or in which he is held by the Secretary of Labor to be able to return to duty, unless he is eligible for continued enrollment as an employee or as an annuitant under a retirement system for civilian employees in which case his enrollment continues without change.

(iii) The day he enters on active duty in a uniformed service for the purpose of performing duty not limited to 30 days or less.

(c) *Coverage of members of the family.* The coverage of a member of the family of an enrolled employee or annuitant terminates, subject to the temporary extension of coverage for conversion, at midnight of the earlier of the following dates:

(1) The day on which he ceases to be a member of the family.

(2) The day the employee or annuitant ceases to be enrolled, unless the member is entitled, as a survivor annuitant, to continued enrollment, or is entitled to continued coverage under the enrollment of another.

(d) *Cancellation.* An enrolled employee or annuitant may register to cancel his enrollment at any time by filing with his employing office a properly completed health benefits registration form. The cancellation becomes effective on the last day of the pay period after the pay period in which the health benefits registration form canceling his enrollment is received by his employing office, except that the cancellation of an employee or annuitant having a monthly or 4-weekly pay period becomes effective at the end of the pay period in which the health benefits registration form is received if the form is received not less than 15 days before the end of the pay period. He and the members of his family are not entitled to the temporary extension of coverage for conversion or to convert to an individual contract for health benefits.

§ 890.305 Reinstatement of enrollment after military service.

The enrollment of an employee or annuitant whose enrollment was terminated because he entered on duty in a uniformed service for a period of time not limited to 30 days or less is reinstated automatically on the day the employee is restored to a civilian position pursuant to Part 353 of this chapter or other similar authority or on the day the annuitant is separated from the uniformed service, as the case may be.

(a) *Change to self alone.* The effective date of a change of enrollment under § 890.301(f) is the first day of the first pay period after the health benefits registration form is received by the employing office, except that at the request of the employee or annuitant and upon a showing satisfactory to the employing office that there was no family member eligible for coverage by the family enrollment, the change may be made effective as of the first day of the pay period following the one in which there were no family members.

(b) *Annuitant required to change enrollment.* The effective date of an annuitant's change to a lower cost enrollment under § 890.301(p) is immediately upon termination of his prior enrollment.

(c) *Open season.* (1) The effective date of a change in enrollment under § 890.301(d)(2) is the first day of the first pay period beginning on or after March 1, 1965.

(2) The effective date of a new enrollment under § 890.301(d)(2) is the first day of the first pay period beginning on or after March 1, 1965, which follows a pay period during any part of which the employee or annuitant is in pay or annuity status.

(d) *Generally.* The effective date of any other enrollment or change of enrollment is the first day of the first pay period which begins after the health benefits registration form is received by the employing office and which follows a pay period during any part of which the employee or annuitant is in pay or annuity status.

§ 890.307 Waiver or suspension of annuity or compensation.

(a) Except as provided in paragraph (b) of this section, when annuity or compensation is entirely waived or suspended, the annuitant's enrollment continues for not more than 3 months (not more than 12 weeks for annuitants whose compensation under the Federal Employees' Compensation Act is paid each 4 weeks). If the waiver or suspension continues beyond this period, the annuitant's enrollment is terminated, subject to the temporary extension of coverage for conversion, effective at the end of the period. It is reinstated automatically when payment of annuity or compensation is resumed, and the employing office shall make the withholding for the period of suspension or waiver during which enrollment was continued.

(b) If suspension of annuity or compensation is because of reemployment, the reemploying office shall make the withholding currently and enrollment continues during reemployment.

Subpart D—Temporary Extension of Coverage and Conversion

§ 890.401 Temporary extension of coverage and conversion.

(a) *Thirty-one day extension and conversion.* An employee or annuitant whose enrollment is terminated other than by cancellation of the enrollment or discontinuance of his plan, in whole or part, and a member of the family whose coverage is terminated other than by cancellation of the enrollment or discontinuance of the plan under which he is covered, in whole or part, is entitled to a 31-day extension of coverage for self alone or self and family, as the case may be, without contributions by the enrolled person or the Government, during which he is entitled to exercise the right of conversion provided for by this part. A change from self and family to self alone operates as a cancellation as to the members of the family. The 31-day extension of coverage and the right of conversion for any person ends on the effective date of a new enrollment under this part which covers the person.

(b) *Continuation of benefits.* (1) Any person who has been granted a 31-day extension of coverage in accordance with paragraph (a) of this section and who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the plan during the continuance of the confinement but not beyond the 60th day after the end of the temporary extension.

(2) Any person whose enrollment has been changed from one plan to another, or from one option of a plan to the other option of that plan, unless because of the discontinuance of the plan in whole or part or pursuant to an order of the Bureau of Retirement and Insurance, and who is confined in a hospital or other institution for care or treatment on the last day of enrollment under the prior plan or option, is entitled to a continuation of the benefits of the prior plan or option during the continuance of the confinement, but not beyond the 91st day after the last day of enrollment in the prior plan or option. The plan or option to which enrollment has been changed shall not pay benefits with respect to that person while that person is entitled to continuance of benefits under the prior plan or option.

Subpart E—Contributions and Withholdings

§ 890.501 Government contributions.

(a) The Government contribution for all plans, except those for which another contribution is set by paragraph (b) of this section for each enrolled employee who is paid biweekly is as follows:

For an employee enrolled for self alone	$1.30
For an employee enrolled for self and family	3.12

(b) The biweekly Government contribution for each employee or annuitant enrolled in a plan whose total enrollment charge is less than twice the appropriate contribution listed in paragraph (a) of this section is 50 percent of the enrollment charge.

(c) The Government contribution for annuitants and for employees who are not paid biweekly is a percentage of that fixed by paragraphs (a) and (b) of this section proportionate to the length of the pay period, rounding fractions of a cent to the nearest cent.

(d) The Government contribution for employees whose annual salary is paid during a period shorter than 52 workweeks is determined on an annual basis and prorated over the number of installments of pay regularly paid during the year.

(e) The employing office shall not make a contribution for an employee or annuitant for periods for which withholding is not made.

§ 890.502 Employee withholdings.

(a) The employing office shall make the withholding required from enrolled survivor annuitants from the annuity of any surviving spouse. If that annuity is less than the withholding required, the employing office shall make the withholding to the extent necessary from the annuity of the youngest child, and, if necessary, from the annuity of the next older child, in succession, until the withholding is satisfied.

(b) The employing office shall not withhold from an employee who is in nonpay status, or from an annuitant for periods for which he does not receive annuity.

(c) Withholding for employees whose annual salary is paid during a period shorter than 52 workweeks is determined on an annual basis and prorated over the number of installments of pay regularly paid during the year.

§ 890.503 Reserves.

(a) The enrollment charge consists of the rate approved by the Commission for payment to the plan for each employee or annuitant enrolled, plus 4 percent, of which one part is for an administrative reserve and three parts are for a contingency reserve for the plan.

(b) The administrative reserve is credited with the one one-hundred-and-fourth of the enrollment charge set aside for the administrative reserve. The administrative reserve is available for payment of administrative expenses of the Commission incurred under this part, and for such other purposes as may be authorized by law.

(c) (1) The contingency reserve for each plan is credited with (i) the three one-hundred-and-fourths of the enrollment charge set aside for the contingency reserve from the enrollment charges for employees and annuitants enrolled for that plan, (ii) amounts transferred in accordance with law from other contingency reserves and the administrative reserve, (iii) income from investment of the reserve, (iv) its proportionate share of the income from investment of the administrative reserve, and (v) any return of reserves of the plan. The preferred minimum balance for the contingency reserve is 1 month's subscription charges at the average monthly rate paid from the Employees Health Benefits Fund for the plan during the most recent contract period.

(2) When, as of the end of a contract period, the total of all the reserves held by a carrier (other than a group-practice carrier) for the plan amounts to less than the total of the last 5 months' subscription charges paid from the fund to the carrier for the plan, the carrier is entitled to payment from the contingency reserve of the lesser of: An amount equal to the difference between the total of the last 5 months' subscription charges paid from the fund to the carrier for the plan and the total of the reserves held by the carrier for the plan, or an amount equal to the excess, if any, of the contingency reserve over the preferred minimum balance. The Commission shall authorize this payment after receipt of the accounting report for the contract period. The carrier shall credit the amount so paid to the special reserve for the plan.

(3) If a group-practice carrier's contingency reserve exceeds the preferred minimum balance, the carrier may request the Commission to pay a portion of the reserve not greater than the excess of the contingency reserve over the preferred minimum balance. The carrier shall state the reason for the request. The Commission will decide whether to allow the requests in whole or in part and will advise the plan of its decision.

UNITED STATES CIVIL SERVICE COMMISSION,
[SEAL] DAVID F. WILLIAMS,
Director, Bureau of Management Services.

[F.R. Doc. 64-11028; Filed, Oct. 28, 1964; 8:48 a.m.]

UNITED STATES CIVIL SERVICE COMMISSION
BUREAU OF RETIREMENT AND INSURANCE
Washington, D.C. 20415

Health Benefits Notice

Most health benefits plans under the Federal Employees Health Benefits Program will change their rates or benefits or both effective November 1, 1964. The enclosed booklet explains these changes. ***If your plan is increasing its premium rate, the increase will be deducted for the first time from your December 1, 1964, check which pays annuity for November.***

From February 1 to February 15, 1965, there will be an "Open Season" which permits you to change your enrollment if you wish to do so. During the open season you may make any one—or a combination—of the following changes:

From ***one plan*** to ***another plan***
From ***one option*** to ***another option*** in the same or a different plan
From ***self only*** to ***self and family***

If you decide NOT to change your enrollment, DO NOTHING. If you do nothing, your present enrollment will be continued automatically.

If you want to change your enrollment, fill in the inside part of this notice, tear it off carefully, and mail it to your retirement system promptly. If you want to change, your completed registration form must be received by your retirement system BEFORE FEBRUARY 16, 1965. Any change in enrollment during the open season will be effective March 1, 1965.

On pages 3 and 4 of this notice is a list of participating plans and the eligibility requirements for joining them. Do not request a brochure for a plan if you do not meet the eligibility requirements for joining it.

THE ADDRESS OF YOUR RETIREMENT SYSTEM IS:

BUREAU OF RETIREMENT AND INSURANCE
U.S. CIVIL SERVICE COMMISSION
WASHINGTON, D.C. 20415

(Open this notice—Read inside part also)

BRI 49-252
October 1964

☐ Please send me a registration form only. I want to stay in my present plan, but I want to consider changing from one option to another or from Self Only to Self and Family coverage.

☐ Please send me a registration form, together with a brochure for the following named plan(s). I want to consider changing from my present plan to one of the plans I have named below:

PRINT OR TYPE YOUR FULL NAME, MAILING ADDRESS, AND CLAIM NUMBER	Name
	Street Address
	City, State, and Zip Code
	Claim Number (CSA or CSF)
COMPLETE THIS PART ONLY IF YOU ARE A SURVIVOR ANNUITANT →	Full name of deceased Federal employee and his date of birth

IMPORTANT

Comprehensive medical plans are open only in certain geographic areas.

Employee organization plans are open only to annuitants who are already members of the sponsoring organization.

REQUEST FOR REGISTRATION FORM OR BROCHURES

PARTICIPATING PLANS

Federal Employees Health Benefits Program

Government-wide Plans

Two plans are open to every eligible annuitant no matter where he lives. They are:

Service Benefit Plan. This plan provides benefits generally through direct payments to doctors and hospitals by local Blue Cross and Blue Shield organizations.

Indemnity Benefit Plan. This plan is administered for the insurance industry by the Aetna Life Insurance Company and provides benefits by cash reimbursement to you or, at your option, directly to doctors or hospitals.

Employee Organization Plans

Following is a list of employee organizations which sponsor plans. These plans provide benefits by cash reimbursement to you or, at your option, directly to doctors or hospitals. An employee organization plan is open only to an annuitant who is a member of the organization sponsoring the plan. ***Do not ask for a brochure of a plan sponsored by an organization on this list unless you are now a member of the organization.***

American Federation of Government Employees

American Foreign Service Protective Association

Federal Employees Hospital Association (Formerly Federal Postal Hospital Association)

Group Insurance Board (Panama Canal)

National Alliance of Postal Employees

National Association of Letter Carriers

National Association of Post Office Mail Handlers, Watchmen, Messengers, and Group Leaders

National Association of Post Office and General Services Maintenance Employees

National Federation of Post Office Motor Vehicle Employees

National League of Postmasters of the United States

National Postal Union

National Rural Letter Carriers Association

Special Agents Mutual Benefit Association

United Federation of Postal Clerks

(Continued on other side)

Comprehensive Medical Plans

The plans which are listed below by State are open generally to annuitants who are in the particular geographic area served by the plan. They are either group-practice plans which provide benefits in the form of medical services by teams of doctors and technicians practicing in their own medical centers, or individual-practice plans which provide benefits in the form of direct payments to doctors with whom the plans have agreements. Both types of plans also provide hospital benefits.

The list shows only the general area served by each comprehensive plan. ***Do not request a brochure for a comprehensive medical plan unless you reside in the general area served by the plan. Then check the brochure to be sure it covers your specific area.***

Plan	*General Area Served*
CALIFORNIA	
Foundation for Medical Care	Counties of San Joaquin, Calaveras, Tuolumne, Stanislaus, Sonoma, and Riverside
Kaiser Foundation Health Plan	San Francisco metropolitan area
Kaiser Foundation Health Plan	Los Angeles metropolitan area
Physicians and Surgeons Association	Los Angeles and San Diego
Ross-Loos Medical Group	Los Angeles metropolitan area
DISTRICT OF COLUMBIA	
Group Health Association (GHA)	Washington, D.C., metropolitan area
HAWAII	
Hawaii Medical Service Association (HMSA)	State of Hawaii
Kaiser Foundation Health Plan	Island of Oahu
IDAHO	
North Idaho District Medical Service Bureau	North Idaho, and Asotin County in Washington
MICHIGAN	
Community Health Association (CHA)	Detroit metropolitan area
MINNESOTA	
Group Health Plan	Minneapolis-St. Paul
NEW YORK	
Group Health Insurance (GHI)	Eastern New York State and upper New Jersey
Health Insurance Plan (HIP)	Greater New York
OREGON	
Kaiser Foundation Health Plan	Portland metropolitan area
Physician's Association Plan	Clackamas County
National Hospital Association	Certain counties in northwestern Oregon and southwestern Washington
WASHINGTON	
Bridge Clinic	Greater Seattle area
Group Health Cooperative of Puget Sound	King County
Letter Carriers Medical Service Plan	Greater Seattle area
Washington Physician's Service (WPS)	State of Washington, except Yakima County
Western Clinic	Pierce County
PUERTO RICO	
Seguros De Servicio De Salud (SSS)	Puerto Rico

(Please see other side)

GPO : 1964 OF—744-142

U.S. CIVIL SERVICE COMMISSION
Bureau of Retirement and Insurance
Washington, D.C. 20415

Information for Annuitants

about the

Federal Employees Health Benefits Program

This pamphlet contains important information about the Health Benefits Program. Refer to it when you have a question about the program. Refer to your plan's brochure for information about the plan's benefits. Keep the brochure and this pamphlet handy.

BRI 41-118 August 1964

Dear Annuitant:

Your enrollment in a plan under the Federal Employees Health Benefits Program has been continued. As an annuitant enrolled under this Program, you are entitled to—

- The same benefits, and the same rates, that apply to active employees enrolled in your plan
- Continuation of the Government's contribution toward the cost of your plan
- Automatic payment of your share of the cost, through deductions from your annuity check
- Guaranteed protection against cancellation of your enrollment by your plan
- Continued protection, after your death, for your eligible survivor annuitants (if you have a Self and Family enrollment)
- Temporary extension of coverage without cost to you if your enrollment, or that of a family member, is terminated for any reason unless you voluntarily cancel or change to a Self Only enrollment.

You should continue to use the identification card you now have. If you lose your identification card, write directly to your plan to ask for a new one.

Send all claims for benefits to your plan—not to your retirement system. The address of your plan is listed in the brochure which explains the benefits of the plan.

Bureau of Retirement and Insurance
U.S. Civil Service Commission
Washington, D.C. 20415

TABLE OF CONTENTS

TYPES OF ENROLLMENT

There are two types of enrollment in each plan—

1. ***Self Only.***—This enrollment provides benefits only for you.

2. ***Self and Family.***—This enrollment provides benefits for you and for all eligible members of your family.

FAMILY ENROLLMENTS

Eligible family members.—If you have a Family enrollment, your "family" includes your wife (or husband) and your "children," including your legally adopted children. Your stepchildren and foster children also are included if they live with you in a parent-child relationship.* "Children" must be unmarried and, unless disabled, under age 21. *Your "family" does not include other relatives, even though they live with you and are dependent on you.*

Disabled children over age 21.—A child incapable of self-support because of a disability which began before his 21st birthday may continue to be covered as a family member after his 21st birthday. If you have a child so disabled and have already established that fact with your former employing office (or with your retirement system), you need take no further action unless your retirement system asks for another medical certificate. If you have a child so disabled but have not yet established that fact because he is still under 21, you should so inform your retirement system at least 60 days before his 21st birthday. Your retirement system will then tell you what information should be included in the required medical certificate.

Foster children.—A foster child for health benefits purposes is a child whom you are raising as your own and who lives with you. There must exist an expectation that you will continue to rear him indefinitely into adulthood. A child temporarily

*Stepchildren and foster children of a deceased employee or annuitant are included if they were living with the decedent in a parent-child relationship at the time of his death.

living with you is not a foster child; neither is one placed in your home by a welfare or social service agency which retains control of the child and pays for his maintenance.

New family members.—If you have a Self and Family enrollment, any new family member—such as a newborn child or the newly married wife or husband of a *retired employee* (not a survivor annuitant)—is automatically covered by your health benefits plan. You need take no action to include that person in your enrollment, but your plan may ask you for information about him.

If you are enrolled for Self Only and acquire a new family member, you may change to a Self and Family enrollment as shown on pages 6 and 7.

When a family member loses eligibility.—A family member will automatically lose his eligibility and his coverage as shown below:

WHEN A FAMILY MEMBER LOSES ELIGIBILITY	
Your wife or husband----	upon divorce or upon annulment of marriage.
A child under 21--------	upon marriage or upon reaching age 21.
A disabled child over 21--	upon marriage or upon recovery of ability to support himself.
Any survivor annuitant--	upon marriage.

It is your responsibility to notify your retirement system *promptly* when your *last* family member dies or loses eligibility so that your enrollment may be changed to Self Only with a corresponding reduction in cost to you. This reduction will not be effective until *after* you notify your retirement system.

SPECIAL NOTICE TO SURVIVOR ANNUITANTS

If you are receiving annuity as the widow or widower of a deceased employee or annuitant and you remarry, you will lose eligibility and coverage because remarriage cancels your eligibility as a member of the former employee's family. You *must* therefore notify your retirement system immediately upon remarriage regardless of whether you are enrolled for Self Only or for Self and Family.

OPPORTUNITIES TO C

(Applicable to Annuitants

You may voluntarily cancel your enrollment, or c
However, your cancellation or change to Self Only will
ment system in writing that you want to cancel or cha
cannot be reinstated, and you cannot later enroll in an
ment only on specified occasions and within certain tim

To make any of these changes, write to your retire
the event which permits the change, and the date on whic

Events Which Permit Change
Move from an area served by a comprehensive medical plan in which enrolled at time of move. (See page 11.)
Change in marital status. (Not applicable to survivor annuitants because marriage results in loss of their eligibility.)
Other change in family status. (For example, birth of a child.)
Termination of enrollment by employee organization plan because of termination of membership in organization.
Termination of plan in which enrolled.
Self Only enrollment of spouse covered as an employee under this program terminates as a result of change in spouse's Federal employment status.
Separation from active military service which was not limited to 30 days or less.
NOTE: If a member of your family covered under your Sel employee, and loses coverage under your enrollment may be eligible to enroll in a health benefits plan. write to his retirement system for information.

Effective dates of changes in enrollment.—T
generally will be the first day of the month after the onc
tirement system. If you are a compensationer under the
will be at the beginning of a pay period, rather than th

Survivor annuitants who are also Federal em
rollment of a spouse at the time of the spouse's death
annuitant also is an eligible Federal employee he or sh
the enrollment as an employee terminates for any rea
as a survivor-annuitant enrollment. To request this, wr
of your last employing office.

If your retirement system receives your letter wit
will be effective on the day after your enrollment ter
after your separation, your reinstatement will be effec
received.

HANGE ENROLLMENT

and Survivor Annuitants)

hange from Self and Family to Self Only, at any time. not become effective until *after* you notify your retire- nge to Self Only. Once you cancel your enrollment, it ther plan. You may make other changes in your enroll- e limits, as stated in the following table.

ment system stating exactly the change you wish to make, h that event occurred.

	From Self Only to Family	From One Plan or Option to Another	Time Limit in Which Election to Change Must be Filed With Your Retirement System
	Yes	Yes	Any time after move.
	Yes	Yes	From 31 days before to 60 days after change in marital status.
	Yes	No	Within 60 days after change in family status.
	No	Yes	Within 31 days after termination of enrollment in plan.
	Yes	Yes	As set by the Civil Service Commission.
	Yes	No	Within 31 days after spouse's enrollment is terminated.
	Yes	Yes	Within 31 days after separation from service.

f and Family enrollment is also an annuitant, or is a Federal for any reason other than by your cancellation, he (or she) In the event of such loss of coverage, the annuitant should

he effective date of any of the changes indicated above in which the request for change is received by your re- Federal Employees' Compensation Act, the effective date first day of a month.

ployees.—A survivor annuitant covered under the en- may continue the spouse's enrollment. If the survivor e may elect, instead, to be enrolled as an employee. If son (other than by cancellation), it may be reinstated ite your retirement system, giving the name and address

hin 60 days after your separation, your reinstatement minated. If your letter is received more than 60 days tive on the first day of the month after your letter is

CONTINUATION OF ENROLLMENT

In case of death.—If you should die while enrolled for Self and Family, your eligible survivor annuitants (and any other family member eligible for continued coverage) will be able to continue your enrollment. Their share of the cost of the plan will be deducted from their annuity check. If there is only one survivor annuitant and no other family member is eligible for continued coverage, his enrollment will be changed automatically to Self Only, with a corresponding reduction in cost.

If annuity is suspended.—If annuity is suspended or waived, your coverage and that of your eligible family members will continue for up to 3 months (up to 12 weeks if you are a compensationer under the Federal Employees' Compensation Act) and will then be terminated. If payment of annuity is resumed, health benefits coverage will be reinstated and withholdings will be made retroactively for the period of time your coverage was continued without deductions.

Temporary extension of coverage.—Your coverage will continue temporarily for 31 days after your enrollment is terminated for any reason except voluntary cancellation. In addition, if you are confined in a hospital on the 31st day of your temporary extension, your benefits will continue while you are confined, up to a maximum of 60 additional days. These temporary extensions are without cost to you. The same temporary extensions also apply to any family member covered by your enrollment who loses his eligibility for any reason except your voluntary cancellation of the enrollment, or unless you change your Self and Family enrollment to Self Only.

TERMINATION OF COVERAGE

Employee annuitants.—Except in certain cases where an annuitant is reemployed, your coverage and enrollment as an annuitant will automatically

end, subject to the temporary extension of coverage, on the last day of the month for which you are entitled to annuity.

Survivor annuitants who remarry.—If you are receiving survivor annuity as the widow or widower of a deceased employee or annuitant, your coverage and enrollment will automatically end, subject to the temporary extension of coverage, on the last day of the month preceding the one in which you remarry. If any children continue to receive survivor annuity, they may continue the enrollment but you will not be covered.

Entry into military service.—If you enter on active duty in the military service for a period of time which is not limited to 30 days or less, your enrollment will be terminated, subject to the temporary extension of coverage, on the day you enter such active duty. Your enrollment will be reinstated on the day you are separated from military service. During the 31 days after separation, you may change your enrollment from one plan or option to another or from Self Only to Self and Family. To be sure these actions take place, promptly notify your retirement system in writing of your entry into, or return from, active military duty, and submit a copy of your military orders with your letter.

Cancellation.—If your retirement system receives your request for cancellation at least 15 days before the end of the month (or 15 days before the end of the pay period if you are a compensationer under the Federal Employees' Compensation Act), your cancellation will become effective at the end of that month (or pay period). If your request is received less than 15 days before the end of the month, your cancellation will become effective at the end of the next month.

Family members.—The coverage of any family member automatically ends, subject to the temporary extension of coverage, on the day on which he loses eligibility as a family member as explained on page 5, or on the day that the enrollment terminates.

CONVERSION RIGHTS

If your enrollment in a health benefits plan ends for any reason other than voluntary cancellation, you are entitled to convert to a nongroup health benefits contract issued by the carrier of the plan in which you are enrolled. If this occurs and if you are interested in conversion, apply promptly to the nearest office of your plan for information about the nongroup contract. Nongroup conversion policies are issued without evidence of insurability.

When a member of your family loses his eligibility for coverage under the group plan in which you are enrolled (as, for example, when a child reaches 21), then that family member is entitled to convert to a nongroup contract with that same plan. *You will not be notified by your retirement system when a family member loses eligibility.* Therefore, when this occurs, and if you are interested in conversion, apply promptly to the nearest office of the plan in which you are enrolled for information about a nongroup contract to cover that person. If a family member loses coverage because you cancel your enrollment or change it to Self Only, the family member does not have conversion rights.

Written application for conversion to a nongroup contract normally must be made to the carrier, and the first premium must be paid to the carrier, within 31 days after coverage under the group plan ends. A converted nongroup contract becomes effective at the end of the 31st day of the temporary extension of coverage described on page 8.

Many plans do not provide the same benefits under the converted nongroup contract that they provide under the Federal employee group plan, and the premium rates for converted nongroup contracts are different. The Government will not contribute toward the cost of the nongroup conversion contract. If you need to know the benefits and cost of the converted nongroup contract, get in touch with your plan.

REMINDER TO PERSONS IN COMPREHENSIVE PLANS

If you are enrolled in one of the plans listed below, which provide service only in certain areas, you may change to another plan if you permanently move out of the service area of your plan. This change should be requested as soon as possible after you move.

Bridge Clinic Plan, Seattle, Wash.
Community Health Association Plan, Detroit, Mich.
Foundation for Medical Care, Stockton, Calif.
Group Health Association, Washington, D.C.
Group Health Cooperative Plan, Seattle, Wash.
GHI Family Doctor Plan, New York, N.Y.
Group Health Plan, St. Paul, Minn.
HMSA Plan, Honolulu, Hawaii
Health Insurance Plan (H.I.P.), New York, N.Y.
Kaiser Foundation Health Plan, Los Angeles, Calif.
Kaiser Foundation Health Plan, San Francisco, Calif.
Kaiser Foundation Health Plan, Honolulu, Hawaii
Kaiser Foundation Health Plan of Oregon, Portland, Oreg.
Letter Carriers Medical Service Plan, Seattle, Wash.
Medical Service Bureau Plan (North Idaho District), Lewiston, Idaho.
National Hospital Association Plan, Portland, Oreg.
Physicians Association Plan, Oregon City, Oreg.
Physicians and Surgeons Association Health Plan, Los Angeles, Calif.
Ross-Loos Medical Group, Los Angeles, Calif.
SSS Plan, Santurce, Puerto Rico
Washington Physicians Service, Seattle, Wash.
Western Clinic Plan, Tacoma, Wash.

GOVERNMENT'S CONTRIBUTION NOT "INCOME"

The Government contribution toward the cost of your health insurance under this program is—

- NOT "income" for Federal income tax purposes,
- NOT "income" for veterans benefits purposes,
- NOT "wages for services" for social security purposes.

IMPORTANT

Whenever you find it necessary to write to your retirement system be sure to include your *signature*, your *retirement claim number*, and the *date of your birth*. Also *print* your name and address and, if you are a survivor annuitant, the name of the former Federal employee on whose service your annuity is based.

UNLESS ANOTHER ADDRESS IS SHOWN BELOW, THE ADDRESS OF YOUR RETIREMENT SYSTEM IS:

BUREAU OF RETIREMENT AND INSURANCE
U.S. CIVIL SERVICE COMMISSION
WASHINGTON, D.C. 20415

☆ U.S. GOVERNMENT PRINTING OFFICE: 1964—O-738-124